COMMONWEALTH of VIRGINIA

ERIC S. BELL
DIRECTOR

Department of Medical Assistance Services

600 EAST BROAD STREET
RICHMOND, VA. 23219
PHONE: (804) 786-7933
FAX: (804)225-4512

Medicaid Claims Request

Date:_____

Agency:_____

Worker's Name:_____

Phone No:_____

Recipient Audit Unit Supervisor
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Dear Supervisor:

I am conducting an investigation of the person(s) listed below for the time period indicated. Please forward proof of claims paid by Medicaid during the investigative period.

I will keep you informed of additional progress and of the outcome of this investigation.

Case Name:_____ Base ID#:_____

(a)_____ Recipient ID#:_____

Period of suspected fraud/overpayment:_____

(b)_____ Recipient ID#:_____

Period of suspected fraud/overpayment:_____

(c)_____ Recipient ID#:_____

Period of suspected fraud/overpayment:_____

(d)_____ Recipient ID#:_____

Period of suspected fraud/overpayment:_____

Sincerely,

Custodian Certificate/Claims needed? Y/N
Expected Date to the CA:_____
Expected Court Date:_____
DMAS-750R (7/00)